STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments An unannounced complaint survey, Complaint Number 2019007757 and Complaint Number 2019007761, was conducted on at Florida Palms Academy, a , Residential Treatment Facility. The facility is not in compliance with Code of Federal Regulations (CFR) 42, Part 483.354 Subpart G, Condition of Participation for , Residential Treatment Facilities. One Condition level deficiency was identified to be out of compliance at 42 CFR Part 483.350 Use Of And . Fourteen Standard level deficiencies were identified to be out of compliance, N0140, N0145, N0149, N0151, N0152, N0153, N0154, N0155, N0165, N0167, N0188, N0189, N0193 and N0196. The effect of these systemic practices resulted in the , Residential Treatment Facility's inability to assure the resident's needs would be met.	N 000		
N 100	USE OF AND CFR(s): 483.354 Subpart G: Condition of Participation for the Use of and in , Residential Treatment Facilities Providing Inpatient , Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on review of the , Residential Treatment Facility (PRTF)'s Policies and	N 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 100	Continued From page 1 Procedures, record review and interview, it was determined the PRTF failed to: Ensure a physician's order was obtained for a by a physician, or other licensed practitioner permitted by the state and the facility to order and trained in the use of emergency safety interventions (N0140), Ensure a -to- assessment of the physical and well-being of the resident was conducted within 1 hour of the initiation of the emergency safety intervention by a physician, or other licensed practitioner trained in the use of emergency safety interventions (N145), Ensure documentation of the intervention in the resident's record by the end of the shift, in which the intervention occurs (N149), Ensure the documentation of the time the emergency safety intervention actually began and ended (N151), Ensure the documentation of the time and results of the 1-hour -to- assessment (N152), Ensure the documentation of the emergency safety situation that required the resident to be restrained (N153), Ensure the documentation of the name of staff involved in the emergency safety intervention (N154), Ensure the maintenance of a record of each emergency safety situation, the interventions used, and their outcomes (N155), Ensure the clinical staff was trained in the use of emergency safety interventions physically present, continually assessing, and monitoring the physical and well-being of the resident and the safe use of throughout the duration of the emergency safety intervention (N165), Ensure a physician, or other licensed practitioner	N 100		

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N 100	Continued From page 2 permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, evaluate the resident's well-being immediately after the . . . . . is removed (N167), Ensure a -to- discussion within 24 hours after the use of the . . . . . with staff involved in an emergency safety intervention and the resident (N188), Ensure a debriefing session was conducted that includes a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention within 24 hours after the use of . . . . . with all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff (N189), Ensure the documentation in the resident's record that both debriefing sessions took place and included in that documentation the names of staff who were present for the debriefing, names of staff who were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings (N193) and Ensure medical treatment was immediately obtained from qualified medical personnel for a resident injured as a result of an emergency safety intervention (N196). The . . . . . effect of these systemic practices resulted in the . . Residential Treatment Facility's inability to assure the resident's needs would be met.	N 100		
N 140	ORDERS FOR USE OF . . . . . OR CFR(s): 483.358(a)	N 140		

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N 140	Continued From page 3	N 140		

Orders for [redacted] or [redacted] must be by a physician, or other licensed practitioner permitted by the State and the facility to order [redacted] or [redacted] and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient [redacted] services for beneficiaries under [redacted] are provided under the direction of a physician.

This STANDARD is not met as evidenced by:
Based on review of the [redacted] Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to obtain a physician's order from a board certified psychiatrist or licensed physician for the use of a manual [redacted] for 1 of 3 sampled residents (Resident #1).

The findings included:

Record review of the facility's policy titled, "[redacted] and Manual [redacted] Policy," dated [redacted] and revised on [redacted], reveals evidence of documentation that the use of manual [redacted] is limited to emergencies in which there is imminent risk of an individual physically harming himself, staff or others, and non-physical interventions would not be effective and only a board certified psychiatrist or licensed physician can order [redacted] or [redacted]. Record review reveals Resident #1 was admitted to the facility on [redacted] and discharged on [redacted] with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on [redacted] on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their [redacted], ate 100% of their meal and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 140	Continued From page 4	N 140		

snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.
Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of .
Review of Resident #1's record lacked any evidence documentation that a physician's order was obtained for a as required.
In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy.
In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on ., called the Nurse Manager and the , and they sent the resident to the , .
In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone."
A review of the facility's document titled

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N 140	Continued From page 5 "Correspondence" dated [redacted] revealed, during morning 15-minute checks of "North Hallway," on [redacted], Staff E noticed that Resident #1 had visible red marks to the and [redacted]. Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on [redacted], Staff A, stated, "I restrained Resident #1 three times last night."	N 140		
N 145	ORDERS FOR USE OF [redacted] OR CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and [redacted] wellbeing of residents, must conduct a [redacted]-to-[redacted] assessment of the physical and [redacted] wellbeing of the resident, including but not limited to- (1) The resident's physical and [redacted] status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on review of the [redacted] Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the	N 145		

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N 145	Continued From page 6 PRTF failed to follow their own policies and procedures and conduct a -to- assessment of the physical and well-being of the resident, within one hour of the initiation of , by a licensed practitioner for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself, staff or others, and non-physical interventions would not be effective and that within one hour of the initiation of a a Physician, Registered Nurse (RN) or Advanced Registered Nurse Practitioner (ARNP) must conduct a -to- assessment of the physical and well-being of the resident. Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and	N 145		

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N 145	Continued From page 7 stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of ..... Review of Resident #1's record lacked any evidence of documentation that a ...-to-... assessment of the physical and , , well-being of the resident within one hour of the initiation of , by a licensed practitioner was completed as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on ..... at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on ....., called the Nurse Manager and the , and they sent the resident to the , ... In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of an undated "correspondence," from Staff H, a RN (Registered Nurse) working on ....., stating that there was no report of client injuries, or incidents on the 3:00 PM-11:00 PM shift on ..... to the Nursing Department by Staff A. A review of the facility's document titled	N 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 145	Continued From page 8 "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 145		
N 149	ORDERS FOR USE OF OR CFR(s): 483.358(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: This ELEMENT is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document a by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies	N 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 149	Continued From page 9 in which there is imminent risk of an individual physically harming himself ,staff or others and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which . . . . occurred; the order, the time the intervention began and ended, the time and results of the . . .-to- . . . assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on . . . . and discharged on . . . . with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their . . . , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated . . . . . at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . . . . . . Review of Resident #1's record lacked any evidence that the . . . . documentation was completed by the end of the shift in which it occurred, as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors	N 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 149	Continued From page 10 and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the and they sent the resident to the , . In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 149		
N 151	ORDERS FOR USE OF OR CFR(s): 483.358(h)(2) [Documentation must include] the time the emergency safety intervention actually began and ended.	N 151		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 151	Continued From page 11	N 151		

This ELEMENT is not met as evidenced by:
Based on review of the , Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the failed to follow their own policies and procedures to document the time a actually began and ended, by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1).

The findings included:

Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself ,staff or others, and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which occurred; the order, the time the intervention began and ended, the time and results of the -to- assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention.
Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00-11:00 PM Mental Health Technician (MHT) Shift Note, Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries.

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N 151	Continued From page 12	N 151		

No problem behaviors during shift. No safety precautions during shift.
Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night.
Continued review reveals there was no evidence of documentation of a report of .
Review of Resident #1's record lacked any evidence documenting the time the actually began and ended, by the end of the shift in which it occurred as required.
In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy.
In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , and they sent the resident to the , .
In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone."
A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 151	Continued From page 13 that Resident #1 had visible red marks to the . . . and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . . . . . , Staff A, stated, "I restrained Resident #1 three times last night."	N 151		
N 152	ORDERS FOR USE OF OR . . . . . CFR(s): 483.358(h)(3) [Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. This ELEMENT is not met as evidenced by: Based on review of the , Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document the results of the 1-hour assessment by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated . . . . and revised on . . . . , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which occurred; the order, the time the intervention began and ended, the time and	N 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 152	Continued From page 14 results of the -to- assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . Review of Resident #1's record lacked any evidence documentation related to the 1 hour assessment was completed by the end of the shift in which it occurred, as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , and they sent	N 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 152	Continued From page 15 the resident to the , ... In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 152		
N 153	ORDERS FOR USE OF OR ..... CFR(s): 483.358(h)(4) [Documentation must include] the emergency safety situation that required the resident to be restrained or put in . This ELEMENT is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document the emergency safety situation that required the resident to be	N 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 153	Continued From page 16	N 153		

restrained by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1).

The findings included:

Record review of the facility's policy titled, " and Manual Policy," dated and revised on ., reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which occurred; the order, the time the intervention began and ended, the time and results of the -to- assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention.
Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.
Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 153	Continued From page 17	N 153		

Continued review reveals there was no evidence of documentation of a report of .
Review of Resident #1's record lacked any evidence documentation as to the reason of the emergency safety situation that required the resident to be restrained was completed, by the end of the shift in which it occurred as required.
In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy.
In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , and they sent the resident to the , .
In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone."
A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 153	Continued From page 18 Resident #1 three times last night."	N 153		
N 154	ORDERS FOR USE OF . . . OR CFR(s): 483.358(h)(5) [Documentation must include] the name of staff involved in the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on review of the , Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document the name of staff involved in the . . . . . , by the end of the shift in which it occurred for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated . . . . . and revised on . . . . . , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others, and non-physical interventions would not be effective and that staff documents the following information by the end of the shift in which occurred; the order, the time the intervention began and ended, the time and results of the -to- assessment, the emergency situation that required the resident to be restrained and the name of staff involved in the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on . . . . and discharged on	N 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 154	Continued From page 19	N 154		

with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on [redacted] on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their [redacted], ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.

Further review of the record revealed "Nursing Notes," dated [redacted] at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of [redacted].

Review of Resident #1's record lacked any evidence documentation of the names of staff involved in the [redacted] was completed, by the end of the shift in which it occurred as required.

In an interview conducted on [redacted] at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " [redacted] Packet" available for review because it was not completed as per the PRTF's policy.

In an interview conducted on [redacted] at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on [redacted], called the Nurse Manager and the [redacted] and they sent the resident to the [redacted].

In an interview conducted on [redacted] at 2:09 PM, Staff F, Floor Manager states the incident happened on [redacted] on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 154	Continued From page 20 called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 154		
N 155	ORDERS FOR USE OF OR CFR(s): 483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on record review and interview, the Residential Treatment Facility (PRTF) failed to maintain a record of each emergency safety situation, the interventions used, and their outcomes for the use of a manual for 1 of 3 sampled residents (Resident #1). The findings included: Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record	N 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 155	Continued From page 21	N 155		

revealed documentation that on [redacted] on the 3:00-11:00 PM Mental Health Technician (MHT) Shift Note, Resident #1 showered, brushed their [redacted], ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.

Further review of the record revealed "Nursing Notes," dated [redacted] at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of [redacted].

Review of Resident #1's record lacked any evidence documentation of the emergency safety situation, the interventions used and their outcomes for the use of a manual [redacted], completed as required.

In an interview conducted on [redacted] at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " [redacted] Packet" available for review because it was not completed as per the PRTF's policy.

In an interview conducted on [redacted] at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on [redacted], called the Nurse Manager and the [redacted], and they sent the resident to the [redacted].

In an interview conducted on [redacted] at 2:09 PM, Staff F, Floor Manager states the incident happened on [redacted] on the 3:00 PM- 11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 155	Continued From page 22 instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 155		
N 165	MONITORING DURING AND AFTER CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and well-being of the resident and the safe use of throughout the duration of the emergency safety intervention. This STANDARD is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to continually visually assess and monitor the physical and well-being of the resident for the safe use of throughout the duration of the for 1 of 3 sampled residents (Resident #1).	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 165	Continued From page 23 The findings included: Record review of the facility's policy titled, "[illegible] and Manual [illegible] Policy," dated [illegible] and revised on [illegible], reveals that the use of manual [illegible] is limited to emergencies in which there is imminent risk of an individual physically harming themselves ,staff or others, and non-physical interventions would not be effective and that staff trained in the use of emergency safety interventions shall be physically present and continually visually assessing and monitoring the physical and [illegible] well-being of the resident and the safe use of [illegible] throughout the duration of the emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on [illegible] and discharged on [illegible] with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on [illegible] on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their [illegible], ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated [illegible] at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of [illegible]. Review of Resident #1's record lacked any evidence documentation that the resident's physical and [illegible] well-being was visually	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 165	Continued From page 24 assessed and monitored during the . . . . . and throughout the duration of the as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on . . . . . at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on . . . . . ., called the Nurse Manager and the , . . and they sent the resident to the , ... In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on . , Staff E noticed that Resident #1 had visible red marks to the . . . and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . . . . . , ..., Staff A, stated, "I restrained Resident #1 three times last night."	N 165		
N 167	MONITORING DURING AND AFTER . . .	N 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 167	Continued From page 25 CFR(s): 483.362(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the is removed. This ELEMENT is not met as evidenced by: Based on record review and interview, the Residential Treatment Facility (PRTF) failed to have a physician, or other licensed practitioner evaluate the resident's well-being immediately after the is removed for 1 of 3 sampled residents (Resident #1). The findings included: Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence	N 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 167	Continued From page 26 of documentation of a report of ..... Review of Resident #1's record lacked any evidence of documentation that a physician or other licensed practitioner evaluated the resident's well-being immediately after the was removed as required. In an interview conducted on ..... at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " ..... Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the ..... and they sent the resident to the . In an interview conducted on ..... at 2:09 PM, Staff F, Floor Manager states the incident happened on ..... on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated ..... revealed, during morning 15-minute checks of "North Hallway," on ....., ..., Staff E noticed that Resident #1 had visible red marks to the and ..... Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 188	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the or , staff involved in an emergency safety intervention and the resident must have a -to- discussion. This discussion must include all staff involved in the intervention except when the presence of a staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of or and strategies to be used by the staff, the resident, or others that could prevent the future use of or . This STANDARD is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to conduct a -to- discussion (debriefing) after the use of a with staff involved in an emergency safety intervention and the resident within 24 hours for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies	N 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 188	Continued From page 28 in which there is imminent risk of an individual physically harming themselves, staff or others, and non-physical interventions would not be effective and the facility notifies and processes with the parent/guardian of the resident who was restrained and documents the notification and staff person who provided the notification and within 24 hours post . the staff involved in the intervention and the resident have a -to- discussion, which includes the staff involved in the intervention. Record review reveals Resident #1 was admitted to the facility on . . . . and discharged on . . . . with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their . . . , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated . . . . at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . . . . . . Review of Resident #1's record lacked any evidence documentation that a . . . -to- . . . discussion (debriefing) after the use of a with staff involved in an emergency safety intervention and the resident within 24 hours was conducted as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was	N 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 188	Continued From page 29 notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the and they sent the resident to the , . In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 188		
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of or , all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a	N 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 189	Continued From page 30 debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on review of the , Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to conduct a debriefing session that includes a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention within 24 hours after the use of with all staff involved in the emergency safety intervention, and appropriate supervisory and administrative for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming themselves, staff or others and non-physical interventions would not be effective and that the facility staff involved in the intervention as well as appropriate members of the treatment team will conduct a debriefing session within 24 hours post	N 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

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N 189	Continued From page 31 Record review reveals Resident #1 was admitted to the facility on . . . . and discharged on . . . . with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their . . . . , ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated . . . . . at 2:09 PM revealing that Resident #1 came into the Nursing Office and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of . . . . . . Review of Resident #1's record lacked any evidence documentation that a debriefing session that includes a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention within 24 hours after the use of with all staff involved in the emergency safety intervention, and appropriate supervisory and administrative was conducted as required. In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on . . . . . at 2:53 PM,	N 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

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N 189	Continued From page 32 Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , and they sent the resident to the , . In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on , Staff A, stated, "I restrained Resident #1 three times last night."	N 189		
N 193	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff who were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings. This ELEMENT is not met as evidenced by: Based on review of the , Residential	N 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 193	Continued From page 33	N 193		

Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to document in the resident's record that both debriefing sessions took place and any changes to the resident's treatment plan that result from the debriefings for 1 of 3 sampled residents (Resident #1).

The findings included:

Record review of the facility's policy titled, "[redacted] and Manual [redacted] Policy," dated [redacted] and revised on [redacted], reveals that the use of manual [redacted] is limited to emergencies in which there is imminent risk of an individual physically harming himself ,staff or others, and non-physical interventions would not be effective that staff document, in the resident's record that both debriefings sessions took place and any changes to the resident's treatment plan resulting from debriefing.

Record review reveals Resident #1 was admitted to the facility on [redacted] and discharged on [redacted] with diagnoses that made the resident eligible for the program. A review of Resident #1's record revealed documentation that on [redacted] on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their [redacted], ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift.

Further review of the record revealed "Nursing Notes," dated [redacted] at 2:09 PM revealing that Resident #1 came into the Nursing Office and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 193	Continued From page 34	N 193		

stated that they were restrained by staff last night.
Continued review reveals there was no evidence of documentation of a report of .
Review of Resident #1's record lacked any evidence documentation that both debriefing sessions took place and any changes to the resident's treatment plan that result from the debriefings was completed as required.
In an interview conducted on at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " Packet" available for review because it was not completed as per the PRTF's policy.
In an interview conducted on at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on , called the Nurse Manager and the , and they sent the resident to the , .
In an interview conducted on at 2:09 PM, Staff F, Floor Manager states the incident happened on on the 3:00 PM- 11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1, instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone."
A review of the facility's document titled "Correspondence" dated revealed, during morning 15-minute checks of "North Hallway," on , Staff E noticed that Resident #1 had visible red marks to the and . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 193	Continued From page 35 , Staff A, stated, "I restrained Resident #1 three times last night."	N 193		
N 196	MEDICAL TREATMENT FOR INJURIES CFR(s): 483.372(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention. This STANDARD is not met as evidenced by: Based on review of the Residential Treatment Facility (PRTF)'s Policies and Procedures, record review and interview, the PRTF failed to follow their own policies and procedures to immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention for 1 of 3 sampled residents (Resident #1). The findings included: Record review of the facility's policy titled, " and Manual Policy," dated and revised on , reveals that the use of manual is limited to emergencies in which there is imminent risk of an individual physically harming himself, staff or others, and non-physical interventions would not be effective and that staff immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention. Record review reveals Resident #1 was admitted to the facility on and discharged on with diagnoses that made the resident eligible for the program. A review of Resident #1's record	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 196	Continued From page 36 revealed documentation that on [redacted] on the 3:00 PM-11:00 PM "Mental Health Technician (MHT) Shift Note," Resident #1 showered, brushed their [redacted], ate 100% of their meal and snack, no problems during mealtime. Took their medication with no problem. Had positive behaviors during shift, interacted well with peers, followed rules and staff direction, had appropriate boundaries. No problem behaviors during shift. No safety precautions during shift. Further review of the record revealed "Nursing Notes," dated [redacted] at 2:09 PM revealing that Resident #1 came into the Nursing Office with multiple visible red marks to the [redacted] and [redacted] and stated that they were restrained by staff last night. Continued review reveals there was no evidence of documentation of a report of [redacted]. Review of Resident #1's record lacked any evidence that immediate medical attention after a [redacted] with injury was obtained for Resident #1. In an interview conducted on [redacted] at 2:21 PM, the Staff I, Program Manager stated she was notified immediately of the incident, was not at the facility but gave direction to the Supervisors and stated that there is no " [redacted] Packet" available for review because it was not completed as per the PRTF's policy. In an interview conducted on [redacted] at 2:53 PM, Staff G, a LPN (Licensed Practical Nurse) stated she assessed the resident on [redacted], called the Nurse Manager and the [redacted], and they sent the resident to the [redacted]. In an interview conducted on [redacted] at 2:09 PM, Staff F, Floor Manager states the incident happened on [redacted] on the 3:00 PM-11:00 PM shift, Resident #1 reported to Staff E, that Staff A, restrained them the night before, 3 times. Staff D called her and told her about Resident #1,	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10L001	A. BUILDING _____ B. WING _____	C 05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORIDA PALMS ACADEMY	5925 MCKINLEY STREET HOLLYWOOD, FL 33021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 196	Continued From page 37 instructed her to take the resident to "Nursing"... and "I'm on my way. I and another Manager arrived at the facility, interviewed Staff A who admitted that he restrained the resident but didn't call it in or notify anyone." A review of the facility's document titled "Correspondence" dated . . revealed, during morning 15-minute checks of "North Hallway," on . . . . . , ..., Staff E noticed that Resident #1 had visible red marks to the and . . . Resident #1 stated Staff A restrained him three times last night. Staff A contacted Staff F, advising her of the incident taking place on . . , Staff A, stated, "I restrained Resident #1 three times last night."	N 196		